THE

MEDICAL AND SURGICAL REPORTER.

No. 477.] PHILADELPHIA, APRIL 21, 1866. [Vol. XIV.—No. 16.

Original Department.

Lectures.

PHLEGMASIA DOLENS.

A Clinical Lecture Delivered at Pennsylvania Hospital, March 17, 1866.

By J. M. Da Costa, M. D.

Reported by Dr. Napheys.

Isabella M., mother of seven children, was delivered, six weeks ago, of a boy. She had an easy confinement. The third night after delivery, she states that her left knee began to swell, then the thigh, and that the swelling gradually extended down the leg. The pain preceded the swelling, and first affected the knee, to which it was limited, none existing in the groin. From the beginning, it was increased by motion. A gradual swelling took place in the thigh, where she states, contrary to what occurred in the knee, the tumefaction preceded the pain. All this dates six weeks back. When she was admitted into the hospital, which was on the 13th inst., we found a very considerable swelling of the whole of the left leg. It was uniformly swollen to about three times the size of the right, was of a whitish color, and slightly œdematous, especially at the lower portion and around the ankle. There were no signs of inflammation, so far as color is a sign, if we except a slight redness on the inside of the knee. There was everywhere extreme tenderness; indeed, pressure was so painful at various portions of the leg, that we had to desist from accurately noting how far that tenderness extended, or in how far it was modified by position. We could not, at that time, owing to the extreme pain it occasioned, flex and extend the limb, as we found any attempt at motion vastly increased the suffering.

Now, besides all this, in tracing out the phenomena then present, we noticed that although there were spots of tenderness, perhaps most marked at the lower portion of the thigh, they could not be limited to the course of the saphena or femoral vein. Indeed, if we could make any observation on the subject of comparative tenderness, we were bound to assume that in the course of the veins there was less tenderness than elsewhere. But, as I already stated, the great difficulty of making the examination, owing to the pain it occasioned, throws a little doubt upon this observation, but so far as we could determine, we have no hesitation in saying that the course of the veins was not the most painful part of this limb.

The constitutional phenomena we observed at that time were, pulse 120, heart's action quiet, skin moist, appetite impaired, pallid countenance. The treatment we adopted consisted in bathing the part constantly with lead-water and laudanum, good nourishing diet, and subsequently painting the thigh with tincture of iodine, and the internal use of juniper berries.

Since yesterday, we have found the swelling somewhat decreased. We made an attempt at keeping the leg on an inclined plane, but it was too painful. Although the limb has decreased in size since we first observed it, you will now notice that there is yet a great difference between it and the right one. You also perceive that there is still œdema about the ankle, and though there is some tenderness here, the tenderness, she states, and I believe correctly, is not so great as it was formerly. But the closer the knee is approached, the greater still is the pain.

Notice the character of the swelling. It is white, firm-looking, and only slightly pits on pressure near the knee. The knee-joint itself is red, and there is evidently considerable effusion here. The red spots you see are the ones I told you existed from the beginning, being the only signs of discoloration present at any part. You can hardly now judge of the state of the thigh, because of the iodine with which it has been painted. But the skin does not pit on pressure, differing from the leg in this respect—or at most, there is the least appreciable pitting in some parts. Moreover, there is still considerable tenderness. I press now in the course of the femoral vein, and there is clearly no more pain, to say the least, than elsewhere. She states it did not hurt her there. But, as you see, a little above the knee-joint, about two inches, in a straight line with the patella, seems to be the

seat of greatest tenderness, as it has always been. I will add, to complete the observation, that the thigh presented, before it was painted, exactly the appearance of the leg, namely, it was white, shiny, and had none of the red marks you see on the knee-joint.

Now, before we proceed to further discussion of the case, we will examine the groin. There is no tenderness about or above Poupart's ligament. Pressure immediately above the symphysis pubis gives on left side some pain, none on right. She cannot move the limb. She feels contact. Tickling of sole of foot produces no reflex movement, neither does she move much when I tickle the right foot. We will investigate the state of the muscles of the limb, and using the term in very general sense, we cannot but state that the impaired power of motion amounts to palsy.

Now, the case you have before you is a typical one of phlegmasia dolens, milk leg, phlegmasia alba dolens, painful white swelling. This, studied in its symptomatic relations, with reference to the phenomena it presents, is interesting, I think for many reasons. In the first place, let us ask ourselves how what we observe here differs from what would be observed in a case of marked œdema of the leg, as in general dropsy. It differs in this, that the swelling, except at the lower portion, does not pit much on pressure, indeed, in this instance, there is even more pitting than we often perceive. Notice, further, that the part is white, shiny, dense.

As regards some of the symptoms, I would further call your attention to two points of great interest. One is the loss of power in the leg. I do not think it is easy to explain this loss of power. In a few minutes, when discussing the pathology of the affection, I shall recur to this point. The other condition I wish you to particularly notice is the very great tenderness here present, and the fact that the tenderness is very diffused, and by no means limited to the course of the veins; indeed, if we can trust to the observations made, it is less there than elsewhere. So as to complete this examination, we will test the muscles by galvanism. I am not aware that this test has ever been made use of in cases of this kind. We will see what it leads to, or whether we observe anything at all of importance; in any event, it will complete our investigation.

Now, as we apply the current, there is certainly no increased electro-cutaneous sensibility, for she does not feel it any sooner nor more distinctly than I do. I am also willing to affirm that there is deficient manifestation of electro-muscular sensibility in the muscles over which I am now applying the current on the inner side of the leg. There is also deficient electro-muscular contractility in the muscles of calf of the leg. I now localize the current on the rectus, and there is no contraction perceptible. There is much greater sensibility, as you instantly perceive, in the right limb than in the diseased one. The results of this examination, then, are that there is undoubtedly slightly diminished electro-muscular sensibility in the diseased, as contrasted with the sound leg, for you observed that the same current produced much more pain on the right side than on the left, and there is unquestionably diminished or less electro-muscular contractility; at all events, the contractions of the muscles, if produced, can neither be felt or seen.

Now, having pointed out to you the clinical elements of this case, I think it may serve a useful purpose, for us to discuss for a few minutes the pathology of this affection. What is it? Why this swelling? If you had asked that question of a pathologist of the last century, or even of the beginning of this, you would have been told that it is emphatically a milk leg, that this white, shining, comparatively non-pitting swelling was due to a large accumulation of milk in the leg. After this view had passed away, the prevalent one was that this kind of swelling was caused by some disease of the lymphatics. It was supposed to be kindred in its nature to angeioleucitis. But observations have proved the incorrectness of this surmise. Until quite recently, these milk legs have been supposed to be owing to phlebitis. It has been assumed, especially in the milk leg that follows delivery, that the veins of the uterus first became involved in inflammation, which extended to the iliac and femoral veins, perhaps to the saphena, and thus we had the signs you have here so clearly developed. This view is still held by a number of pathologists, and by obstetricians in particular. But there are many reasons for believing it to be erroneous in most instances. And certainly, in the first place, the best of all reasons is that persons in whom this affection has proved fatal, have not presented the least sign of any inflammation of a vein; and on the other hand, if you tie a vein, producing artificial inflammation in it with subsequent clotting, you have marked œdema, but you will not have the pain, the comparatively uncedematous swelling and the loss of motion you have here. Therefore, partly as the result of clinical and pathological observation, and partly as the result of experiments upon animals, we cannot hold strongly to

the opinion that inflammation of a vein, with subsequent occlusion of its calibre, in consequence of that inflammation, is the primary cause of phlegmasia dolens. Again, and it is very important for you to take a more general view than would be furnished by any one case that might be presented to you, we find phlegmasia dolens arising after low fevers, in phthisis, in cancer, and in states of the system which do not favor the view of a likelihood of venous inflammation.

I may at once here state that the most probable cause that has been assigned for this disease consists in the coagulation of blood, not simply in the large veins, but in the smaller order of veins; not merely in the femoral and saphena, but also in all the veins, even to the fourth and fifth order, connected with them. These facts rest partly on the result of experiments, such as were made by Mackenzie; partly also on clinical observation, for in cases which have proved fatal, and in which accurate examination has been made, this plugging of both larger and smaller veins has been often found to a marked degree. The coagulation in the veins is probably the result of the altered state of the blood, and only in much rarer instances is it due to phlebitis.

Having told you this, let us now try and explain the symptoms in the case I exhibited to you. These you still see are present to a certain degree—indeed I am sorry to say to a very great degree. You still find the swelling, which, comparatively speaking, pits but little on pressure; still the sensitiveness to the touch, especially on the thigh; still the inability to move her leg; still the perspiring skin, the frequent feeble pulse, and the signs of considerable debility co-existing. Taking as our ground-work what I have just told you as to the cause of this affection, let us enter upon an explanation of the swelling, the pain, the increased temperature, and the want of motion which this case presents.

First, as to the swelling. Is it œdema? No, it is not. There is some œdema unquestionably mixed up with it, but you could not have a leg œdematous to such an extent without its pitting more on pressure. I shall in the next clinic show you a case of Bright's disease, with marked œdema. You will then find, so soon as we press upon it, our fingers leave a marked depression visible for some time. The swelling here, then, is not that of pure œdema, but is the result partly of œdema, partly of the plugging of the venous system, and possibly, too, (as Graves long since believed, even prior to the introduction of the doctrine I am now bringing to your notice,) of some inflammation of the tissues proper, extending around and obliterating small veins.

Why should the disease be so painful? Why this tenderness so great, and so unlike what happens in cases of œdema? You have got one cause in the distention of the blood-vessels—a state which is always painful. And, moreover, I think it is very likely that this distention presses upon some of the smaller nerve branches. What more likely? Could you have so much swelling, partly from and not altogether œdematous, as we know this to be, without there being pressure upon the fine nerve branches? This pain and tenderness are so marked, that there are not a few distinguished pathologists who have believed this disease to consist primarily in neuritis, affecting the finer nerves. But the most careful investigations after death have not detected any signs of inflammation of the nerves. I think we may conclude that the pain is greatly due to mechanical causes, to the swelling pressing upon the nerves, and to the fulness of the blood-vessels of the part.

Two interesting points remain for our discussion. As to the increased temperature, we have not merely the result furnished by the hand, but we have made with the thermometer a comparative observation upon the two limbs. 104° is the temperature of the left leg, and 102° of the right. What does this increased temperature denote? Could mere œdema cause it? If so, the œdematous parts of Bright's disease ought to be of higher temperature. Increased temperature favors the view of local disturbance of circulation, and favors the view of some inflammation of tissue. By the way, let me here mention in passing, that this doctrine of inflammation does not rest wholly upon theoretical basis, but that in some cases absolute partial suppuration occurs with a disease of this kind. The increased temperature, I believe, is partly the result of the obstructed venous circulation, and partly, perhaps—I think we may also say—of the inflammation of which I have spoken.

One more, and that a very interesting point of its symptomatology, remains to be studied, namely, the loss of motion.

First, you will say, is it a fact? I appeal to this and other cases. Then you will ask if it is mechanical, the leg being too heavy. Have any of you ever seen a case of elephantiasis? Doubtlessly you have. Is not the leg heavy enough then, increased to twice the size of this leg even, and yet have you not seen persons walk with elephantiasis? Again, take a case of marked œdema of both legs in Bright's disease, or cardiac

dropsy. The patient is not necessarily bed-ridden; he can kick and contract his limbs, at all events. Where then stands the mechanical explanation here, in view of such much more marked enlargement in elephantiasis and œdema, in whch motion is fairly possible, and can indeed be readily performed? Why can our patient not move the muscles of this affected limb? Thus then, gentlemen, we are drawn to the conclusion that the difficulty is not purely mechanical, owing to the weight of the part. I think there is here real paralysis present. That acute observer, whom I have already quoted with reference to the view as to inflammation of the part in this disease—GRAVES, was so struck with the want of power which these cases of phlegmasia evinced, that he regarded it as reflex palsy. He said the cutaneous nerves are affected primarily, and react upon the spinal column, and this disorders the muscular motions; or, in other words, the want of muscular power is reflex.

But we must be careful in attributing to reflex-palsy—a state so little understood—any phenomena that seem capable of readier explanation in other ways. It would appear more likely that the pressure upon the nerves I have spoken of, which is borne out by the pain, might be placed in connection with this want of power. You well know if you disorder the nervous supply of a part by pressing upon the nerves distributed to it, you have not only pain but diminished motion. Also, we notice, as the swelling decreases the power increases. I would then say, that the loss of motion is partly the result of mechanical pressure on the nerve trunks and nervous branches—fine as well as larger; but I do not think this view wholly covers the ground.

I am also inclined to believe that the state of the blood which is here present, and which is most likely the cause of the coagulation which has taken place in the veins, has something to do with the loss of power in the limb. This, then, I offer as the explanation of the evident want of power, which amounts, I may say, to real palsy. I might easily have linked with this the result of some very interesting observations which I commenced before you, and which we have carried on since our last meeting, in regard to the electrical phenomena of the helpless limb; but time will not permit, and I must leave their discussion to some other time, or some other case.

But a few words as regards the treatment, which consists in keeping the part elevated, and swathed in lead-water and laudanum, supporting the patient, and acting upon the emunctories. Act upon the bowels, if you can do it without weakening the patient too much, and upon the skin, and above all, upon the kidneys. In this case we are administering compound spirits of juniper and quinine, and chloride of iron and good nourishment. I shall show you the case again while it is in progress—and like all cases of the kind, I am afraid it will be a long one—and then discuss with you at greater length than our time this morning permits of, the reasons for the treatment adopted.

Communications.

DEFECTIVE AND IMPAIRED VISION.

With the Clinical Use of the Ophthalmoscope in their Diagnosis and Treatment.

BY LAURENCE TURNBULL, M. D.,

Of Philadelphia, Pa.

(Continued from page 228)

Binocular Vision.

When we look at a carte de visite portrait with the aid of a magnifying glass, there is a certain amount of relief imparted to the object; this can be further increased with the aid of the magic-lantern, producing the most beautiful effect, with a series of photographs of celebrated statues, bringing them out so round in all their beautiful proportions, and illustrating the effect of monocular relief. But to obtain a more perfect idea, even one slightly exaggerated, both eyes must converge to the object, so as to obtain binocular effect. The angle at which this is most perfect, is called the binocular parallax. This angle, supposing the object to be twelve feet distant, and the space between the eyes to be two and a half inches, would be exactly *one degree*, and at twenty-four feet *half a degree*. In those persons in whom the eyes are widely separated the binocular parallax will be greater, and in those in whom the eyes are near together it will be less. To exhibit these effects, "WHEATSTONE" invented a reflecting stereoscope, which essentially consists of two mirrors placed with their backs toward each other, at an angle of 90°, with two sliding frames, upon which the pictures may be attached and properly adjusted. Sir DAVID BREWSTER invented soon after another form of stereoscope, in which the rays from the two pictures are made to diverge to the desired distance, by means of two eccentric double convex lenses placed in sliding tubes, so as to be drawn in and out to suit different eyes, and by which, within certain limits, any desired magnifying effect may be produced. This is the instru-

ment with which we are now so familiar, and which affords so much pleasure by its surprising effects. BREWSTER denies that WHEATSTONE was the discoverer of the fact of two dissimilar pictures being painted upon the retina by near objects, which he says was well known to EUCLID more than two thousand years ago, and Mr. J. Z. LAURENCE has published that the same fact was quite clearly stated by GALEN one thousand five hundred years ago, and "that it is the mental combination of two different perspective projections of the object formed on the retina that conveys to us the idea of solidity."

Binocular Ophthalmoscopes.—The Binocular Ophthalmoscope of Giraud Teulon.

"At a time when all optical instruments, spectacles, telescopes, microscopes, stereoscopes, and so forth, had been successfully constructed in accordance with the physiological principle of binocular vision, the ophthalmoscope was still left to stand alone. The law of its action, that the rays of light emerging from the eye return in the track of their incidence, seemed to present an insurmountable obstacle to the attainment of the conditions of binocular vision. Dr. GIRAUD TEULON, however, in considering the position of the actual inverted aëreal image formed between the ophthalmoscope object-lens and the observer, was led to inquire why the rays diverging from this image should not be seen as readily with both eyes as with one. He found the difficulty to depend upon the distance to which it would be necessary for the observer to retire.

"If the centres of the observer's eyes were from 2″ to 2½″ apart, the focal length of the objective 2″, and the diameter of the pupil of the observed eye 3‴, the observer's eye would require to be 20″ from the image. If the pupillary diameter were only 1‴, the other elements of the calculation remaining the same, the distance would have to be increased to five feet.

"It is apparent that, even in the former case, from loss of light and diminution of the visual angle, no details of the fundus oculi would be discernible.

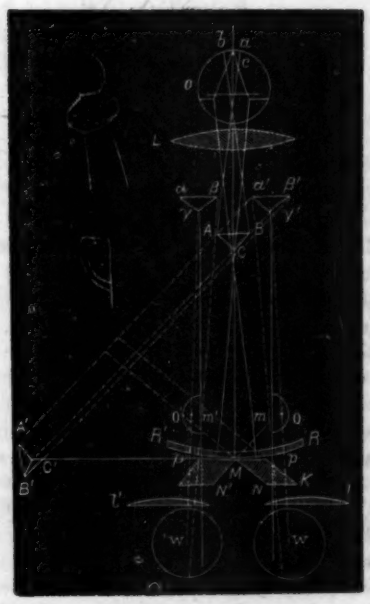
"Dr. GIRAUD TEULON next provided himself with a concave mirror of about 30 centimetres focus, and as large as that of the ordinary laryngoscope. In its horizontal diameter he made an oblong slit, 7 centimetres in length, and 6 millimetres in breadth, through which both eyes could look at once. By placing a lamp above and behind the patient, in a vertical plane with the eye to be examined, the pupil of which must be fully dilated, an observer may see the optic disk, say with the right eye in the ordinary way. After a while, he will see it also with the left eye, the two images partly overlapping one another.

"The two images thus obtained have a great tendency to separate and to vanish behind the pupillary margin. By great practice and very extreme convergence of the ocular axes, it is sometimes possible to unite them and to produce a stereoscopic effect.

"Having thus theoretically solved the problem of binocular ophthalmoscopy, Dr. GIRAUD TEULON sought to render his discovery available in practice. M. NACHET, Jr., had long before constructed a microscope in such a manner that the actual image formed by its objective was divided by a system of prisms and presented at once to both eyes of a spectator. Acting upon this principle, Dr. GIRAUD TEULON placed behind the opening of a mirror, two rhombs of glass, with their edges meeting on the vertical diameter of the opening, and their surfaces ground to afford a complete double refraction at angles of 45°. By this means, the rays proceeding from the actual image of the fundus oculi were divided, and like those of stereoscopic pictures, were easily so united by the aid of lenses or prisms as to afford an appearance of relief.

In Fig. 1, let *a b c* be an object on the background of the examined eye, *L* the convex lens,

FIG. 1.



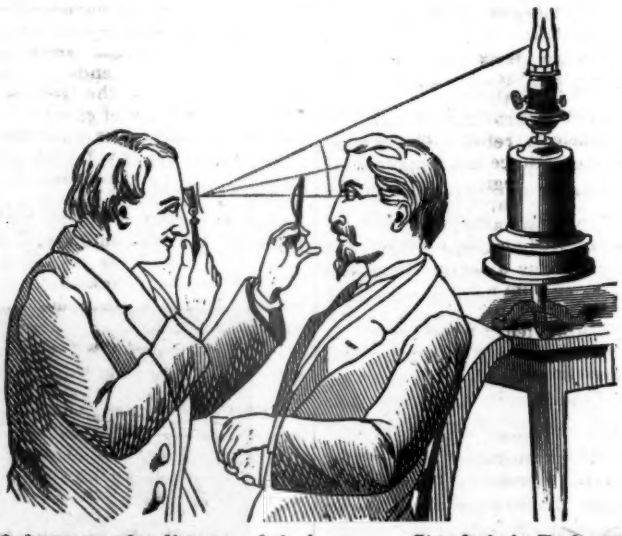
R R′ the perforated concave mirror, *N N′* the two rhombs of glass, *l l′* the ocular lenses before the eyes of the observer, and *A B C* the actual image of

the object; $\alpha\ \beta\ \gamma$, and $\alpha'\ \beta'\ \gamma'$ will then represent the two inverted images formed by the rhombs, and these will blend together. The retina will exhibit its real thickness; the vessels issuing from the papilla will appear as trunks, with twigs projecting forward toward the retinal surface; and the papilla itself will be displayed in its actual condition, either concave, plane, or convex.

If the mirror and the observer's eyes are now brought nearer to the patient, and the instrument be fitted with prismatic decentered convex ocular glasses, as in the common stereoscope, the image assumes great magnitude, the eye under inspection disappears from view; and there only remains an aëreal picture, relatively of immense size, 'any description of which would be inadequate, and would appear exaggerated.' From the extent of the image, and according to a well-known property of the convex glass required as an objective, the whole surface will present an appearance of anterior convexity.

"As already mentioned, the lamp for this examination is placed above and behind the patient; so that the rays pass over his head. The mirror is attached to a horizontal bar turning on pivots upon the horizontal box that contains the rhombs, and no lateral movements are required for the necessary illumination. The rhombs must be kept perfectly horizontal, and the eyes of the observer and patient must be upon the same level. The general arrangement is exhibited in Fig. 2.

Fig. 2.



"In this ophthalmoscope, the distance of the actual image from the observer is less, by half the distance between the eyes, than in a monocular instrument. The mirror may, therefore, have a shorter focal length than in the latter; and the examination may be made from a nearer point. Myopic observers require simple ocular prisms of 7° or 8°. Hypermetropic, or presbyopic, require convex lenses, decentred by about one centimetre, which exert, moreover, a considerable magnifying power. For the examination of the erect image, the mirror must be brought close to the eye, and the convex oculars replaced by concaves, of from 6″ to 10″ focal length. Both kinds are decentred, and are placed, the concaves with their thin edges inward, and the convex with their thin edges outward."*

* Zander.

Strychnia in Prolapsus Ani.

A case is quoted by the *Cincinnati Lancet and Observer*, in which *prolapsus of the rectum*, occurring in a little girl, 4 years of age, inmate of the Foundling Hospital in Paris, yielded to injections, in the direction of the sphincter, at about one third of an inch beyond the anus, of 10 drops of a solution containing 3 grains of sulph. strychniæ in 5 drachms of distilled water. Improvement took place until the third day, when the procidentia recurred once after stool. 14 drops of the solution were again injected, and for six weeks the symptoms did not recur. Later the prolapsus reappeared under the influence of chicken pox, but disappeared again after its subsidence.

Koch, of Stuttgart, effected a cure in a case of 15 years standing, by the employment of cold water injections, medicated by the addition of 12 drops of tincture of nux vomica. Dr. A. Johnson has been equally successful by the application of strychnia (gr. 1-16), to a blistered surface over the coccyx.

Hospital Reports.

Philadelphia Hospital,
December 8th, 1865.

Medical Clinic of Dr. J. L. Ludlow.

Reported by A. M. Shew, M. D., Resident Physician.

Chronic Diarrhœa.

This man I present as a type case of a very prevalent disease that has produced such fearful havoc in our army. It is a peculiar condition of the bowels arising from miasmatic influence and excessive fatigue.

James Smith, æt. 20, by trade a coppersmith, has been a soldier in Virginia, and was with McClellan all through the Peninsular campaign. During all this time he had intermittent fever, and some trouble with his bowels, but was able to attend to his duties, and was not therefore admitted to hospital. After serving as a soldier two years, he was discharged on account of a wound in the left leg.

Came home unable to work; no chills, but a looseness of bowels. During the last few months he has been out in the country working on a farm, and paying particular attention to his diet, but has found no relief. As you perceive, his general appearance indicates that he has been in a malarious region; there is that peculiar palor—a bronze appearance, almost pathognomonic of miasmatic affections.

Now you are aware, gentlemen, that diarrhœa may be brought on by a variety of causes; a change of diet; water from a limestone region to one unaccustomed to its use; excessive heat or cold; severe fatigue; fear; travelling to one of sedentary habits; in short, anything that will produce a decided change in the natural functions may bring on diarrhœa. In this man's case it seems to be connected with miasmatic influence; how we cannot tell. According to his own account no medicine has yet been taken. In regard to quinine in these cases it frequently produces a change, and the patient recovers, providing it has not been of long duration. Place them in the recumbent position removed from the malarious influence. Do not allow them to walk about on any consideration, when of an acute character, the remedies must be of a general antiphlogistic nature; first prepare the system by small alterative doses of calomel or blue mass, ipecac., and opium, and then you may use an astringent with some hope of success. Small doses of lead, opium and camphor, often repeated, have been a favorite astringent remedy for many years. But this is in ordinary cases. Occasionally it will continue for many months, as in this patient, until it becomes chronic and the patient's system is continually drained by this unnatural discharge. You notice how emaciated he has become—you can count every rib in his body. His food passes without being properly digested; feces thin, yellowish white and very offensive; skin dry; tongue red with thick coating; slight pain; has not suffered from wind; there is a peculiar tenseness about the bowels; a retraction of the abdomen that you will always find in these chronic cases from a malarious cause. Very often you have the liver sympathizing; and again there seems at times to be a predisposition in the atmosphere to the production of diarrhœa. We see this in the common epidemics of July and August; at such a time we should be very careful about our diet, and avoid those articles which are known to be crude and indigestible. During these epidemics many people become frightened and rush to the apothecaries and get hot doses which only increases the danger. Send them home and put them in bed; try and dispel their fear; give them mild but nutritious diet, such as rice, farina, or arrow root, while at the same time you administer some astringent medicine. If exhausted give burnt liquors containing aromatic powders. Hot fomentations, leeches or blisters over the whole abdomen will often be found serviceable. Many patients object to the continued use of lead for fear of producing lead poisoning; but in this house we have used bushels of it, and never saw any evil results. At one time, when scurvy existed in the army, they found that acids had a good tendency, and the diarrhœa cases recovered on the free use of lemons with opium and chlorate of potassa. As I said before the change of water is often the cause; but this may be remedied by boiling every particle of water that is used, and then exposing it in open vessels to the atmosphere. Again they have been treated by nitrate of silver, sulphate of copper or zinc, and by subnitrate of bismuth with decided benefit. This latter article became quite popular in chronic diarrhœa—but it is necessary to use it in herculean doses—say ʒss. to ʒj. every two hours.

Any new remedy will seem to do well for a time, but the discharges return; once in a great while they will entirely recover but in a majority of cases they do not get well. After having been vexed and tormented in this way for months and years, they are ready to resort to any new remedy and when that fails they become miserable, dejected in spirit, give up to despondency, and death ends the scene. You will find in making an examination post-mortem, that the mucous membrane presents a very different appearance from that exhibited in health. Instead of being thin, soft and delicate, it is usually inflamed, thickened ulcerated and sometimes perforated. All through the track of the large bowel may be found mild, old and cicatrized ulcers, showing the length of time that it has existed.

The prognosis in this man's case is very unfavourable; he has had nitrate of silver, bismuth and aromatic liquors internally while injections of starch and laudanum, sweet oil, lime-water and laudanum have been made use of. I have to day an idea of changing the treatment to a caustic dose of nitrate of silver, say ¼gr. every three hours. I do not use this with any particular hope.

This patient died, as prognosticated, a few days afterwards, and the presupposed condition of the bowels, as suggested in the lecture, actually existed; there being a complete change in the

mucous membrane, with ulcerations in various and varying stages, in some instances advanced almost to mortification.

Medical Societies.

PHILADELPHIA CO. MEDICAL SOCIETY.

(Reported by Wm. B. Atkinson, M.D., Recording Secretary.)

November 8th, 1865.

Uterine Displacements.

Dr. J. Cheston Morris remarked:

In accepting the invitation of your Committee to read before you a paper on the subject of Displacement of the Uterus, I feel that I have undertaken a task of no ordinary description. Our great American poet-physician, Dr. O. Wendell Holmes, admonishes us that,

> "You have found your place
> Just in the focus of a nervous race."

Old theories and time-honored opinions are being roughly handled and shaken, as though they were merely the far-reaching guesses at truth of our predecessors; well-meaning old gentlemen indeed, but so occupied with their preconceived philosophical notions, and so destitute of our improved means of investigation, as to preclude our attaching much importance to what they may have thought. The quickly succeeding discoveries and developments of facts in the various domains of the science of medicine, produce a sort of delirium—a phantasmagoric vision before our minds, in the midst of which we find it difficult to seize the various truths, and construct from them a harmonious whole. As instances of this confusion I have but to allude to the various theories propounded with reference to the heart's action; or the discussion on therapeutics and the action of remedies which is agitating the English medical public through the labors of Todd, Inman, Chambers, and Anstie. But the subject for discussion to-night is even more than these, the field where medical controversy rages—the number of antagonists is far greater—in fact no practitioner in the daily exercise of his profession can avoid having the question daily brought before him of how to treat uterine disorders, or placing himself in the ranks of those who support some one of the views now prevalent, as to the significance of uterine symptoms, and their proper treatment.

It is this which makes the subject a difficult one; and I feel that I must beforehand ask your indulgence if I should, in endeavoring to express what I think the profession has gained from the—as yet but partially explored—sea of uterine pathology, encounter perhaps, roughly, views which differ from mine; and glad shall I be, if, from the collision, a spark of truth shall rise to guide us all to a better treatment of a very common and distressing class of diseases.

But at the very threshold of the subject, I am met by the question: Are uterine displacements really to be considered as of any importance whatever? Do we not constantly meet with cases in which the uterus deviates from its normal position, and remains misplaced for a series of years, without producing any of the terrible effects so constantly ascribed to falling of the womb? Are these effects really the consequence of the displacement, or of the condition of the uterus, or the system which has caused the displacement? and if the latter, should not our treatment be solely directed to the treatment of these conditions, and the uterus be left to right itself?

Here then is the first point of division. Let us see what experience has to say on the subject. The first question arises from the extreme frequency of uterine displacements from various causes, and from the fact of which any one may convince himself that the uterus is capable of moving, or rather of being moved from its normal position, to a greater extent than perhaps any other organ of the body, except perhaps the heart, and that these variations of its position, while within the limit of healthy function, do not produce any pain in the healthy organ. So frequent are these malpositions, that an anatomist of no mean pretensions has given us a plate representing the relative position of the internal organs, in which the uterus is anteverted. But to the second question, I would reply in the negative. Frequent as are uterine malpositions in persons enjoying a fair amount of health, a careful investigation of their life-manifestations will almost always lead us to the conclusion that they do not attain to the level of healthy action of which they are capable; and far more frequently we shall find that they are suffering more or less from the symptoms which the special deviation is characterized by.

To the third and fourth questions, answers will be best given when we have considered what are the varieties and alleged or real effects of displacement of the uterus.

The varieties usually recognized are prolapsus, procedentia, retroversion, retroflexion, anteversion, anteflexion, and latero-version. Ascent of the womb should hardly be treated of among uterine displacements, as it never occurs alone, but always with some organic change in the other

pelvic organs, and gives rise to no symptoms that need detain us.

The effects of uterine displacement may be conveniently classified as follows:

I. Those upon the uterus itself, including the functions of reproduction.

II. Those upon neighbouring tissues and organs.

III. Those upon the nervous system and general health.

I. If the uterus is removed from its physiological position, the first effect will be to modify the circulation in its walls. The blood-vessels, especially the veins and venous capillaries, will become congested, and thus the nutrition of the organ will be modified to an extent corresponding with the modified circulation. On this point I would like to enlarge considerably, but feel that it can hardly be necessary in speaking to gentlemen who have listened to Dr. Hodge and Dr. Meigs, both of whom have so ably called the attention of the profession to the symptoms and treatment by mechanical means of uterine disease. From personal observation, I am well satisfied that many cases of subacute metritis, granular erosion of the cervix, and hypertrophy of the womb are due to the congestion caused and maintained by malpositions of the uterus; and while this congestion, recurring frequently from physiological and pathological causes, constitutes our most serious obstacle in permanently relieving uterine disease, we must by no means overlook, if we wish for success, speedy and sure, one of its most direct and persistent causes.

Of course I would not be understood as intending to state that the displacement is always and only the cause of congestion, inflammation, hypertrophy, granular inflammation etc., etc. The mistake has often been made in this, as in every other branch of pathology of considering a symptom as the disease—and hence much of the empiricism which afflicts our science. We must go further in our etiology than the bare fact of diarrhœa, or dropsy, if we wish to treat these conditions successfully—but we should be just as much in error in denying displacement as a cause, in its turn, of disease *i. e.*, of disordered action or want of harmony, in the system, as we would in maintaining that dropsy or diarrhœa produces no evil effects.

Among the more serious ones of these, is to be ranked the effect of displacement upon the capability of conception, or of normal gestation. A great difference is observable in this respect among the different forms: for while prolapsus does not often interfere, except by aggravating the nausea of the first three months, and anteversion is only noticeable, for, sometimes, when excessive, tending to cause abortion by the pressure of the fundus against the pubes, anteflexion, and retroflexion require the greatest care on the part of both physician and patient to prevent abortion. The narrowing of the cavity of the womb, and the interference with the normal circulation through its walls, cause an unhealthy condition of the fœtal membranes; and the slightest disturbing cause will produce the expulsion of the uterine contents. Retroversion and retroflexion also constitute an obstacle to conception. Add to these, that the congested, semi-inflamed condition of the organ frequently prevents the natural satisfaction which should result from coitus, and causes suffering instead.

II. The tilting of the fundus of the uterus forward, as in anteversion and anteflexion, interferes most seriously with the functions of the bladder, causing either frequent micturition, dysuria, incontinence, or sometimes retention. The misery resulting from these troubles is very great, and often compels patients to seek relief when other uterine troubles have been long borne in silence. So also the pressure of the fundus against the rectum, as in retroversion and retroflexion causes tenesmus, constipation, painful stools, often with a sensation of something having to be moved out of the way before a stool can be had. So also simple prolapsus causes intense tenesmus from the pressure upon the sphincter. Not unfrequently an obstinate chronic dysentery, with glairy mucus stools, results from the irritation of the rectum thus maintained for years.

Nor do these evils tend to lessen themselves. On the contrary, when the uterus once deviates from its normal direction, the pressure of the bowels, instead of being divided around it so as to help maintain it *in situ*, is all directed on one side; and every effort at defecation, micturition, standing, sneezing, coughing, etc.,—only makes matters worse. But,

III. These are not all. The effects of the interference with the functions of the bladder and bowels, slight though these may seem to the casual observer, upon the general health are not slow in making their appearance. Indigestion, flatulence, dyspepsia, follow the impaired function of the bowels; while headache, dimness of vision, pain in the loins, and anæmia will often lead us to suspect the kidneys of organic disease. Impoverished blood follows the impaired digestion and deficient elimination; and soon the whole nervous system passes into an irritable

condition, and pains innumerable follow in all parts of the body. This, however, leads me to speak of another set of symptoms, viz., those presented by the nervous system. Besides those due, as I have just mentioned, to the interference by a displaced uterus with the functions of digestion and excretion, and consequent deficient hematosis, we shall find not rarely purely reflex nervous phenomena. The uterus, as has been demonstrated by Dr. Robert Lee, is itself richly provided with nerve-ganglia, and is therefore capable of radiating impressions received by it to other nerve-centres. Experience has convinced me that it does so most frequently: and that many cases of partial or entire paralysis, or hyperæsthesia, on the other hand, acknowledge a uterine origin. The point to which painful impressions are most frequently radiated (next to the awful "small of the back," the uterine origin of which is often, I think, very doubtful,) is the spinous processes of the third and fourth dorsal vertebræ. Close to these nervous centres lie those which control the circulation in the eye; and hence the frequent occurrence of "weak eyes" in uterine disorders. I am not aware that this fact has previously been presented to the notice of the profession.

Next in frequency to this reflex symptom is the interference with the renal function, to which the attention of the profession was first called by Prof. Braun's monograph on uræmic convulsions in pregnancy. I have seen two cases of uræmic convulsions of the most urgent character depending upon uterine irritation in virgins; and have also repeatedly met with cases of partial paralysis depending upon disordered urinary excretion traceable to displacement of the uterus. I have also seen simulative hip-joint and knee disease depending upon uterine displacement, and cured almost instantly by restoring the organ to its natural position.

Having thus answered the questions stated above, we must next consider the causes of uterine displacement, and then conclude with the treatment.

The causes of displacement may be arranged under two heads: those which act directly and mechanically upon the organ and overcome its natural supports, and those which act through the system and according to its laws. Under the former must be included long standing or sitting in one posture, excessive muscular exertions, such as lifting, straining, walking, etc. And under the latter would come the relaxation of the ligaments, fasciæ and other tissues after pregnancy, and in feeble conditions of health, as in recovery from exhausting disease, or in cachectic conditions. Under the latter must also be included uterine congestion, the most frequent and troublesome cause. Due frequently, in virgins, to the non-performance of its functions by the uterus, and to the constantly returning menstrual flux, it tends constantly to aggravate itself and to recur, as pointed out above, by the interference thus produced, to the return of blood from the organ. It thus becomes heavier, and the natural supports are no longer sufficient to keep it in place. In the case of procidentia, this sequence is well illustrated; the floor of the pelvis having given away, the organ becomes congested and inflamed, and other changes then follow.

Upon the subject of treatment I shall be brief. As may be inferred from the views expressed above, I have more confidence in rectifying the position of the uterus, regulating the functions, and improving the hygiene of the patient, than in any specific mode of treatment. Each case must be studied for and by itself, and treated accordingly. One word, however, upon the subject of *pessaries*, which has been fought over ever since medicine became a profession. They must be capable of doing good *sometimes*, or they would have been driven out of use long since; for we must remember that the speculum is at least as old as Aretæus and Paulus Ægineta. Nor does it seem reasonable to me that we should use and advocate splints and other mechanical appliances to keep broken bones at rest while nature is repairing the damage, so that there shall be no more irritation than is unavoidable from the apposited fragments; and yet condemn the use of properly constructed and applied pessaries to enable nature to lessen the congestion and inflammation of the womb. No one would expect to cure a luxated joint sooner without a proper support after reduction than with one. I therefore use pessaries; generally for prolapsus, anteversion, or retroversion, either the glass disc, or what is better, Hodge's pessary of hard rubber: measuring on my finger the distance from behind the pubes to the junction of the neck and body of the uterus, having first placed the latter just high enough to remove the feeling of weight and bearing down, and preferring to use rather too small than too large a pessary first. The width of the pessary should depend on the contractility of the vagina and perineum, the object being to support the curve of the instrument on the soft and yielding floor of the pelvis, which thus acts as a spring.

For anteflexion and retroflexion, as also for obstinate cases of version and chronic uterine

enlargement, I have derived great benefit from the use of Simpson's intra-uterine stem-pessary, or a modification which I made of it some four years since. My modification is simply a sound made of moderately firm speculum metal, with a movable disc, which can be raised or lowered upon the rod, so as always to leave a length free, less by ⅜ to ½ inch than the long diameter of the uterus. The danger of injury to the womb from accidental violence is thus done away. The rest of the sound is bent so as to accommodate itself to the curve of the vagina, and then be so bent upon the abdomen as to fix the fundus in any desired position. The rise and fall of the abdominal walls in breathing corresponds with the natural elevation and depression of the uterus; and I have never as yet seen any of the serious inconveniences and disastrous effects said to have resulted abroad from the use of such instruments. On the contrary, I have repeatedly seen old engorgements, enlargements, and flexions completely relieved by them.

My treatment, then, for uterine displacement is to rectify it as soon as possible, and maintain the uterus in its normal position, if this can be effected without violence to it or the neighboring tissues; to treat inflammation, ulceration, congestion, just as I would treat them in any other part of the body, and to regulate the functions of the patient, her dress and modes of life, etc., so as to lessen in every way the afflux of blood and nervous irritation to the parts. To control congestion, and as a resolvent in chronic metritis, I can speak most highly of the powers of bromide of potassium, which I administer in five-grain doses every three or four hours, in combination with camphor, and sometimes very small doses of ipecac.

The difficulty is to get at the truth as regards the causes of displacement, congestion, etc., in the individual case. These once fairly ascertained and appropriately treated, uterine disease is quite as tractable as any form of disease with which I am acquainted.

PATHOLOGICAL SOCIETY of NEW YORK.

Polypus of Rectum—Fungus of Testicle—Urinary Calculus—Extensive Tuberculosis—Fungus of Nipple—Recurrent Fibrous Tumor—Spontaneous Gangrene.

Among the specimens presented before the Society, April 11th, were the following:

Polypus of Rectum.

Dr. Hutchinson presented this specimen, a polypoid tumor of the rectum, which had been removed from a boy, 13 years of age. He had frequently suffered from disease of the bowels. The first symptoms of the morbid growth occurred about five or six months ago, when there was slight prolapsus. Very little hæmorrhage followed its removal.

Prof. Post stated that the specimen appeared more like fleshy tumor than a true polypus.

Fungus of Testicle.

Dr. Hutchinson presented a specimen of fungous disease of the testicle. It had made its appearance through the anterior portion of the scrotum. Six years ago, the patient had received an injury of the right testicle, the symptoms, however, soon subsiding. When Dr. H. saw the patient, six weeks ago, the fungus mass protruded considerably, the superficial glands of the groin were enlarged, but the iliac glands not. There was no enlargement whatever of the cord. Although there were spots of a specific character on some parts of the body, still the whole history of the case did not warrant any diagnosis but that of simple inflammation—a benign fungous growth.

Urinary Calculus.

Dr. Hutchinson also presented two specimens of urinary calculus. The first had been removed, by the bi-lateral operation of lithotomy, from a child two years and three months of age; it had had, from early life, manifest symptoms of stone in the bladder. The calculus weighed sixty-five grains.

The second had been removed, by the same operation, from a child two years and nine months old. It weighed eighty-five grains.

Extensive Diffused Tuberculosis.

Dr. Thompson presented portions of lung and pleura, obtained from a patient, 41 years of age, who had died at Blackwell's Island. He saw him two days ago, the patient having been transferred, four days previously, from the workhouse to the hospital. He complained chiefly of great difficulty of breathing, although he was able to lie down. The dyspnœa was accompanied by some pain in the chest. Pulse 97, moderately strong; respiratory movements quick. Percussion yielded hardly any signs; there was a fair amount of resonance, and equal anteriorly and posteriorly, except a slight amount of dulness posteriorly over the left side. Auscultation did not reveal any marked symptoms. The respiratory sounds seemed to indicate consolidation about the apex of the left lung, but there were no evidences of pneumonia, except a small crepitation corresponding to the dulness posteriorly. Inspiration was harsh, however, almost tubular, and like that of bronchitis. He also complained

of the abdomen, having had, as he stated, severe inflammation of the bowels some time previously.

As the patient was very weak, stimulating treatment was resorted to. He slept very quietly during the first night, having very little cough and no expectoration—no mucous râles.

The next day, he suddenly became worse; breathing very rapid; patient very faint, gradually sinking, and died in the evening.

On *post-mortem* examination, the lungs were found stuffed with small disseminated tubercles, all over-hard, and but a few having commenced to soften posteriorly. The peritoneum was found adherent almost throughout its whole extent, and tubercles diffused over the intestines; the whole peritoneum was studded with tubercles; so also were the pleuræ. There was no serous effusion in the peritoneum; the patient had had no diarrhœa.

Fungus of Nipple.

Dr. Rodgers presented a fungous tumor of the nipple, removed from a woman, seventy-odd years of age. It had commenced as a small wart about a year ago, took on ulceration next, and then became fungous. The general health of the patient was good.

Recurrent Fibroid Tumor.

He also showed a tumor, removed from a patient in whom it had been reproduced, a similar tumor having been excised about nine months ago, from the arm, near the insertion of the deltoid muscle. The character of the tumor was fibrous, filled in with large numbers of ovoid cells, with two or three nuclei; the first tumor is stated to have been of a very vascular character.

Spontaneous Gangrene.

Prof. Post presented a specimen of spontaneous gangrene of the foot, for which amputation of the leg had been resorted to. It occurred in a woman, forty-eight years of age, who, five months ago, had had an attack of typhoid fever, recovery from which was slow. About two months ago, spontaneous gangrene first appeared at the toes of one extremity, soon extending and involving nearly one-half of the foot. A line of demarcation formed two weeks ago, nearly around the foot. As the patient suffered much, it was thought advisable to amputate, and the operation was consequently performed by the long posterior flap method.

A remarkable feature of the operation was the absence of hæmorrhage from the flaps. The retractor even became hardly soiled; the peroneal artery could not be seen, the anterior and posterior tibial, however, were tied. No bleeding vessels were observed, though the parts were exposed for some time, and tourniquet loosened. Dr. P. considered this an unfavorable symptom. The stump is now very painful, and the prospect not very favorable. The pulsation of the femoral artery on that side was very feeble; there was no movement of the ligatures. No heart disease could be detected; no murmurs, no calcification of the arteries.

Dr. Neumann referred to a case of spontaneous gangrene of Dr. Hutchinson, in which amputation was resorted to, and where there was a total abstinence of hæmorrhage, not even the femoral artery bleeding. There was occlusion of the artery. The patient died in three days.

NEWARK (N. J.) MEDICAL ASSOCIATION.

(Proceedings of March Meeting.)

Discussion on Diphtheria.

Dr. O'Gorman, by appointment, opened the discussion on diphtheria.

The disease, although it bears a modern name, is not a new disease. Authors on the subject generally agree that the descriptions given of severe epidemics in the 16th, 17th, and 18th centuries, by Spanish, Italian, and other writers, under the names, "garotilla," "morbus garotillus," "morbus strangulatorius," "gangrenous, or putrid sore throat," etc., was the same disease to which Bretonneau, in 1826, gave the name, "Diphtheritis, or *angine diphthérique*," and which English authors have described under the name, "*cynanche maligna*, or *membranacea*," which at present we call *diphtheria*, a word signifying a membrane, and applied to the disease on account of a membranous exudation which makes its appearance in the fauces, mouth, and nares, and in the very great majority of cases is pathognomonic.

In opening the discussion, it was not his intention to go into a minute and extensive history of the disease and its pathology, but he would limit his remarks to a few suggestions as they occurred to him from observation in his practice. For all practical purposes, diphtheria may be assumed as appearing under three forms: 1. simple diphtheria; 2, diphtheria with complications; 3, malignant diphtheria.

Simple diphtheria, ordinarily, is very mild. Small membranous exudations make their appearance in the fauces, on the tonsils, nares, unaccompanied by the high fever, and that extreme anæmia and prostration, which characterise the other varieties. This form of the disease generally passes away in three to four days. During the last year, in a school of 100 pupils, he had treated at least 40 who were attacked with this mild form.

In the second form, diphtheria with complications, the diphtheritic deposit is not only more abundant, but from the nares, tonsils, and fauces extends into the larynx and trachea; it is a more fatal form, and in his experience, but one case recovered.

The third form, *diphtheria maligna*, might best perhaps be illustrated by a case, which was observed about a week ago. On Saturday night, a young man commenced to complain of slight soreness of the throat and a little fever, not sufficient, however, in his own estimation, to call a physician. On Sunday, he was able to eat his meals as usual, though feeling slightly worse, still it was thought unnecessary to seek medical advice. When Dr. O'G. saw him on Monday morning at 10 o'clock, the patient was moribund. Pulse 140, soft, and weak; skin of a dark and mottled tinge; respiration 120; great apathy, and he could be roused with difficulty. On examining the throat, the fauces, tonsils, and velum palati were found covered with diphtheritic deposit, of a dark color, the membrane hanging down in shreds. He soon died.

In addition to these three forms of diphtheria, he met with it in the course of other diseases. In a case of puerperal fever, the deposit appeared on the tonsils on the third day, and in two days the patient died. The condition of the pulse and of the abdomen did not warrant so speedy a fatal termination of the case from pure puerperal fever, and he could not but ascribe it to the influence of the diphtheritic poison. It is stated by some authorities to occur as a complication of measles and small-pox, but he had never met with such a case in his practice.

The *sequelæ* of diphtheria form an interesting feature. Motory paralysis is the most frequent. The form most commonly met with, in cases under his observation, is hemiplegia; next paralysis of the muscles of deglutition. In one case, it commenced with a sensation of tingling in the limbs, and slight incapacity of using them, gradually increasing until the paralysis was complete. In another case, the paralysis was entire, extending from the feet upward over the whole body, involving the muscles of respiration, so that finally the act of respiration seemed to be performed by the muscles of the neck alone, which drew the thorax up as if by pulleys, and paralysis of deglutition becoming complete, the patient died.

A sequel frequently observed, especially in adults, are hæmorrhages, more or less copious, from the various passages; the bleeding sometimes amounting to pints and quarts.

Pneumonia may be described as another common sequel, or perhaps, complication of diphtheria, lobular in its form, and frequently accompanied with extension of the diphtheritic deposit into the ramifications of the bronchi.

Deafness and loss of *vision* form another variety of sequelæ.

Some three or four summers since, a form of fever prevailed somewhat extensively in this city and neighborhood, which he was inclined to call *diphtheritic fever*. It is characterized by a somewhat accelerated weak pulse, great prostration, and some diphtheritic deposit, accompanied, in many cases, by frequent bloody discharges and tympanitic abdomen. Cases prevailed in various districts of the town, and other physicians had expressed views similar to his own. These cases were very fatal.

Treatment. Regarding the treatment of diphtheria, it must be of a sustaining character throughout. He had little faith in local medication, but relied on the internal use of quinia, iron, chlorate of potassa, and sustaining diet. The disease, in his opinion, was evidently contagious; the liability of an attack, however, diminishing with the advance in years, and peculiar individual liability influencing its contagion.

When the disease was at first described, it was thought by many to be only a form of scarlatina, and when it first made its appearance here, he was somewhat inclined to take this view. But since then, he had seen sufficient distinctions. In scarlet fever, the deposit and swelling of the throat, even if severe, very seldom, hardly ever appear until after the third or fourth day of the fever; while in diphtheria, the fever and enlargement of the glands appear simultaneously, or the enlarged glands and deposit may even precede the former. There is also a marked difference in the duration, and particularly in the sequelæ of the two diseases. Suppurations, œdema, and dropsy are common in scarlet fever, but he never met with them in diphtheria; and on the other hand, the peculiar sequelæ of the latter are never observed in scarlet fever. There can be no doubt, however, that the malignant form of diphtheria bears much resemblance to the malignant form of scarlatina, and this may be explained on the theory that both diseases are due to a blood-poison, intense and rapid in effect, and acting in a manner somewhat analogous.

Dr. J. D. Osborn mentioned a case recently under his observation, in which the diphtheritic deposit was around the gums and the cavity of the mouth, but none in the throat or on the tonsils, though the latter were somewhat swollen.

The deposit was quite extensive, and accompanied by considerable fever.

Dr. O'Gorman stated that the diphtheritic deposit was not particularly limited to the fauces and air-passages. He had seen a case of diphtheria complicated with pneumonia, in which a blister was applied over the chest; in 24 hours, it was covered completely with the peculiar exudation. True, he had noticed dhiptheritic deposits to occur on a blistered surface, without general diphtheria, from irritation of the surface, but in all these cases it never occurred, as in this instance, before the fourth or fifth day.

Dr. Woodhull remarked that there were few diseases, of the true pathology and nature of which we know less. When the disease first again made its appearance in this section within the last ten years, his father recognized it as a disease which he had seen in his early practice, and which was then almost universally fatal under the depletory treatment of other physicians, while he soon adopted stimulating and sustaining treatment, with greater success.

What is the cause of the disease? The general answer to this question is that it is a blood-poison. But in what does this poison consist? What is the peculiar *materies morbi?* Is it an animal or vegetable parasite, a morbid exhalation from the body, or a miasm? He had examined two specimens of the exuded membrane, and in both instances detected the peculiar parasite described by Laycock, Bretonneau, and others, as occurring in bad aphthæ—the *oidium albicans.* Some authors believe that the disease is owing to the imbibition of this parasite into the blood. In the diphtheritic deposit of blisters the oidium albicans is also found.

He believed the disease to be produced by a poison in combination with a vitiated insalubrious atmosphere. He was not prepared to say that it was absolutely contagious, but certainly highly infectious. What this blood-poisoning is, we cannot as yet determine, but its effects on the heart, brain, kidneys, are certainly like those of malignant typhus or malignant scarlatina.

A word regarding treatment. Prof. Polli had great faith in the use of the sulphites in all septicæmic conditions, and if they are of any benefit we should certainly expect good results in the graver forms of diphtheria, where an extensive blood-poisoning cannot be denied. The experience of some seem to justify their use, and he was inclined to give them a trial in diphtheria, especially as he had used the bi-sulphite of soda with very good success in bad cases of erysipelas.

He thought he had seen much good from the topical application of hydrochloric acid, and also from its internal use, and was even inclined to think that it had a specific action in changing the mucous membranes to a healthy state in diphtheria. From nitrate of silver he had seen little good effect. In a case of severe diphtheria, occurring in a young lady, which one of the gentlemen present saw with him, the membranous deposit extended all over the mouth, fauces, and tonsils, and there was total disabilility of deglutition. The patient was kept alive by large injections of beef-tea and brandy, and hydrochloric acid (1 part to ¾ of glycerine) was applied locally, while as long as she was able to swallow, and after the incapacity of deglutition had passed away, hydrochloric acid was administered with chlorate of potassa. She recovered. The action may be due to the chlorine, which certainly is a great antiseptic.

Dr. O'Gorman had used the bi-sulphite in two cases of diphtheria; in both cases without success. In the first case, the diphtheritic deposit extended from the nares into the larynx, and the patient died. He saw the child, however, and used the remedy before the incursion of regular croupy symptoms. The second case terminated similarly, although here, too, the bi-sulphite had been used almost from the commencement.

Dr. Baldwin remarked, that the success of no treatment, which he had observed, was very flattering. As a general rule, however, we fared best with good nutritious, supporting diet, in mild cases; stimulants, quinine and iron, and some local application containing chlorine, in the graver forms.

In reference to one point alluded to by Dr. O'Gorman, he would state that he had not unfrequently seen it to occur in measles and small-pox; not as a complication, but after convalescence had fairly commenced. In once instance, a patient who was convalescent from small-pox, diphtheria occurred suddenly, and terminated fatally in 24 hours. In a case of convalescence from measles, the patient died from diphtheritic deposit extending into the larynx.

A number of cases of diphtheria occurred during the summer of 1862, in the Ward U. S. General Hospital of this city, in soldiers coming from Harrison's Landing. The exudation was exceedingly abundant, the mucous membrane generally became gangrenous, and the cases ended in death.

The results of antiphlogistic treatment he had never seen, and had no desire of seeing. Regarding nitrate of silver, in strong solution, it had had its advocates; he had seen one case in

which a solution of 80 grains to the ounce was applied. The child died in 20 minutes. In his experience, cases which were not treated locally, seemed to do better than when active topical medication is resorted to.

Dr. Cross had seen the three varieties of diphtheria described by Dr. O'Gorman. The first cases which occurred in his practice made a deep impression on his mind, because they were treated without a distinct diagnosis. It was at the time when the disease first again made its appearance here. The first subject was a delicate female; there were but few membranous patches noticeable, and but slight sore throat. The patient, however, was extremely prostrated, and this led him to resort to stimulants, iron and quinine. She recovered. The next case occurred in a child, and was considered scarlet sore throat, without eruption. Soon, however, a pellicle was present on both tonsils, and the nitrate of silver was applied, he was sorry to say. The disease travelled down the windpipe, and the child died. This was the only case he had ever treated with nitrate of silver. If the nitrate of silver did no harm in itself, it certainly did mischief in children, by the excitement and fright to which the patients are subjected by its application.

Another interesting case had fallen under his observation. The patient was a female child, which he was called to see on account of inability to micturate. On examination the labiæ and vagina were found to be swollen, and covered completely with a dense light-colored exudation, similar to the diphtheritic membrane; the parts being very much swollen, and the retention of urine having been kept up so long that the patient suffered intense pain. Chloroform was given preparatory to introducing the catheter; but the latter procedure was unnecessary, the urine being passed spontaneously under the influence of the anæsthetic. There was no complaint whatever of the throat, or any other local affection, but the general prostration, illness and feebleness of the child was very decided. She recovered under nourishing diet and tonic treatment.

With regard to the cases mentioned by Dr. Baldwin, as having occurred in the hospital, he differed with that gentlemen, as to their being cases of diphtheria. The patients had suffered from camp fever, and the ulcerations and gangrenous condition of the throat he looked upon as resulting from the typhoid condition, loss of vitality, and perhaps a deep scorbutic taint, and not diphtheritic.

Dr. Lehlbach referred to one particulpar point stated by Dr. Cross, namely, the extreme prostration in a case where the local manifestations were but slight. He had suffered from an attack himself, with three other members of his family, during this season, and could bear personal testimony as to the intense feeling of prostration and weakness. In all these cases there was very little diphtheritic deposit. A few patches on one tonsil, and the fauces, slight tumefaction, and pain on pressure of the submaxillary glands of the affected side, with some dysphagia, were all the local symptoms present, while an indescribable sensation of malaise and prostration lasted for four or five days, and then passed off. There was not much febrile excitement, though the pulse was rather more frequent and weaker than normal.

There were many interesting points regarding the pathology and differential diagnosis of diphtheria, but, as the evening had progressed so far, he would reserve his remarks for a future occasion.

Dr. Mills.—If he had understood Dr. O'Gorman correctly, it was claimed that the liability to contagion decreased with advance in years. He would, however, state a fact which seemed to be in contradiction to this statement. A woman, 39 years of age, mother of four children, the youngest recently weaned, was attacked with diphtheria in a very violent form, with extreme prostration; the membrane occupying the pharynx, tonsils, nostrils, of dark, dirty ash color, and the tumefaction so great that she was unable to gargle her throat. He insisted on ordering the children out of the room, but was not obeyed, and invariably on his visits found two or more, not only in the room, but frequently in the same bed with the mother. She recovered, iron being given in large doses, and none of the children took the disease.

Dr. E. P. Nichols alluded to the peculiar effect of the paresis of the deglutatory muscles following diphtheria, giving rise to regurgitation of fluids through the nose, when attempting to swallow, a noticeable instance of which he had seen in the case of the late Dr. T.

☞ We understand that some of the buildings occupied by the late Government Hospitals, near this city, are to be allowed to remain for the present, so as to be used in case of a visitation from cholera this season.

Medical and Surgical Reporter.

PHILADELPHIA, APRIL 21, 1866.

A RETROSPECT.

Many times during our connection with the Medical and Surgical Reporter, we have had occasion to draw largely on the good-will of the profession, but never more so than when we announced, last fall, that we should enlarge and improve the Reporter, and raise its subscription price. Our estimate of expenditure for the current year reached the large sum of $15,000, and involved a very material increase in our circulation to enable us to realize the amount. Again, however, we find that we have not placed our reliance on the profession in vain, as we are in daily receipt of convincing proof that they appreciate our enterprize, and are disposed to sustain it. This is made apparent by the fact that we have received an average of about twenty-five new subscribers a week since the first of January last, with every prospect of a much more rapid increase, and by the following exhibit of our correspondence for the four months ending on the 31st of March:

Alabama	3
Arkansas	1
Connecticut	70
Delaware	21
District of Columbia	45
Florida	2
Georgia	6
Idaho Territory	1
Illinois	110
Indiana	98
Iowa	55
Kansas	1
Kentucky	33
Louisiana	1
Maine	36
Maryland	76
Massachusetts	101
Michigan	65
Minnesota	7
Mississippi	11
Missouri	19
Nebraska	1
New Hampshire	17
New Jersey	209
New York	365
North Carolina	8
Ohio	291
Pennsylvania	507
Rhode Island	27
South Carolina	4
Tennessee	40
Utah Territory	4
Vermont	40
Virginia and West Virginia	72
Wisconsin	23
Office Payments	235
Canada West	5
England	2
Ireland	3
Sandwich Islands	1
South America	2
	2618

It will be seen that we have, during that time, received an average of more than twenty-five letters for each working day of the four months, and that, with the exception of Texas, California, and Oregon, every State and nearly every Territory is represented, and these may be under the head of "Office Payments," as the Reporter goes regularly, we believe, to *every* State and Territory.

We trust that this exhibit will stimulate our readers to renewed efforts to extend the circulation of the Reporter, for the larger our constituency, the better able will we be to expend money on the work, and consequently add to its literary value. The *nationality* of the enterprize is also made apparent by the above exhibit, which shows conclusively that in the Reporter the profession has a great national medical periodical, through the medium of which they can communicate with each other from all sections of the country.

AMERICAN MEDICAL ASSOCIATION.

As we announced recently, the approaching meeting of the American Medical Association, which convenes in Baltimore on the 1st of May, promises to be one of the largest conventions of medical men ever held in America. A correspondent asks whether any steps have been taken by which commutation tickets on the railway lines may be procured for delegates. We see no reason why arrangements of this kind should not be made. They are made for political and religious associations, and why not for associations of medical men, who sacrifice much, both in direct expenditure, and in loss of time, for the public good, in attending these meetings. And there is this difference between the delegates to our medical conventions and to religious and political conventions. A medical man has to pay all his own expenses, and is, besides, subject to considerable loss in fees while absent from his business. On the other hand, a large proportion, if not most of the delegates to our religious and political conventions are salaried men, whose income is little, if at all diminished by their absence from home; and, besides, their expenses are generally paid by the bodies which they represent.

It is a peculiar and unmerited hardship to our profession, and a disgrace to our railway corporations, that we should be denied a privilege that is so freely granted to others; and we cannot help feeling that if proper representations were made in the right quarters, commutation tickets could be procured. Is it too late now for the

Committee of Arrangements to take some action in the matter, if they have not already done so?

MEDICAL AND SURGICAL HISTORY OF THE LATE WAR.*

VII.

Diarrhœa, Dysentery, etc.

Much interesting material has been collected regarding the pathology and treatment of this class of diseases. The origin of the diarrhœa and dysentery of troops is to be sought in no one condition, but in the coöperation of several, each of which should be the subject of hygienic precautions. The scorbutic taint, dependent upon camp diet, is mentioned as one by Dr. Woodward; malarious influences form another; while overcrowding and filth of camps and barracks, the heat of summer, the exhaustion and fatigue of campaigns, and the use of water containing saline or organic impurities, add to the list.

That the scorbutic taint forms one of the main causes of diarrhœa, as observed among the troops during the late war, few will deny who have seen the disease as it occurred in the field. It may be objected that true well-defined scurvy has not occurred in such ratio as to justify us in assuming a general scorbutic taint to have existed among the troops; yet the experience of regimental medical officers, in spite of the low rate of actual scurvy reported, will bear us out in the assertion, that a restricted, "*monotonous*" diet in camp or field, sustained by the troops for any length of time, with the use of hardly any vegetable constituents, has *always* been followed by a large increase of cases of diarrhœa and dysentery, and while the rate of this class of diseases, as reported, is astounding, it must be remembered that thousands upon thousands of cases never were entered upon the reports, the patients not being "*off duty*." Indeed, if medical officers had excused every patient suffering from diarrhœa, at times probably only one-tenth of the army would have been available for duty.

Diarrhœa was the army disease. During the warm season, when troops were lying in camps, after long marches or exhaustive campaigns, if one inspected the sinks of the troops, a good, sound, healthy, solid, or even semi-solid stool was a *rara avis*, and one could form an estimate of the prevalence of diarrhœa without looking at the sick reports. That the want of fresh vegetables was a main cause of this state of things was repeatedly shown, when this want was accidentally supplied—as, for instance, after the terrible Gettysburg campaign, when as soon as the blackberry crop which in that part of Virginia, where the Army of the Potomac then operated, was most abundant, became available—and at once began to show its effects in the improved health of the troops and the rapidly diminishing number of diarrhœa cases.

Bad cooking, too, when the dietary causes of this class of diseases are mentioned, must not be overlooked. The circumstances and exigencies of campaigns rendered it often entirely impracticable to enforce cooking by companies, and often for months each soldier was obliged to cook for himself. If he was well supplied with cooking utensils, he had a pint cup for water, which served to cook coffee in, and another cup, somewhat larger, in many cases an old preserved-fruit can, in which his beef, his pork, his beans, his rice were cooked, if he had them, and perhaps he owned a share with ten others in a frying-pan. The only time frequently available to cook dinner would be after arriving late in the evening at a halting place, and then he would boil his beef, just slaughtered and still warm, for as short a time as possible, to get a night's rest for an early start in the morning. The result was that the supplies of camphor and opium pills in the field companions, or hospital knapsacks, would be exhausted with alarming rapidity, and that, when the troops arrived at some more permanent camp, there would be no end to the cases of diarrhœa which presented themselves at sick-call in the morning. Then the morbid craving of nature, after a monotonous diet of hard bread, pork, and beef, would induce the soldiers to flock to the sutler's tent, where everything unwholesome could be found, and very little conducive to healthy alimentation. Canned fruits, miserable cheese, antedeluvian ginger cakes, mouldy with age, fruit cake that might have been rammed into a gun and fired at the enemy in a case of emergency, sausage of most doubtful constituency, were gulped down in fearful quantities to satisfy this morbid craving, and we speak with a full knowledge of the truth of the statement, when we say that *bad cooking* and the *sutlers* are responsible for thousands of deaths from diarrhœa. None can be more fully impressed than we are with the utter impossibility of any commissary department in the world, however willing to do its duty, and however efficiently organized, to keep armies in full supplies for proper alimentation, under circumstances and campaigns such as have characterized the operations of our armies. But still, in many instances there was neglect, and such neglect as interfered

* Extracts from Circular No. 6. Dr. Otis' and Woodward's Reports.

seriously with the efficiency and *morale* of the troops. The organization of the commissary and sutler's departments was calculated for the peace footing of the army before the war, and in consequence could not but be deficient in its working, when the duties of a gigantic war were thrown upon it.

We have made this digression, not in any spirit of fault-finding, but simply to illustrate another of the important causes of the large prevalence of the diseases under question, which does not strictly perhaps belong to Dr. Woodward's present report, though it will, we have no doubt, be amply discussed in the full medical history of the war.

In our next, the subject will be resumed.

HYGIENIC EFFORT in NEW YORK CITY.

The public, and more especially the medical profession of the country, are just now watching with eager interest the attempt at hygienic reform in that Paradise of filth and disease—New York city. After a long and weary struggle against the politicians and the "rings," the friends of hygienic reform succeeded in obtaining from the New York Legislature a Commission, composed partially of medical men, which is clothed with power to abate nuisances prejudicial to health in the city of New York and environs.

That commission has entered on its work with a vigor and determination worthy of the cause. Clothed with extraordinary powers, with a corps of physicians as inspectors, and a thoroughly organized and efficient police to enforce its mandates, it starts under peculiarly favorable auspices. It has a great work before it. In the prosecution of its object, it must collide with large and powerful moneyed interests, and must expect to meet determined and vigorous opposition from interested persons of perhaps considerable influence. But to offset this, it has the hearty sympathy of the people, and the cordial support of a powerful, all-pervading, press. These are auxillaries of no mean importance.

Disease has long revelled in the streets and alleys, the shanties and tenements of the metropolis, almost unmolested. "Unmolested," did we say? We should have said that it has been encouraged and fostered. And now, hovering near is that dreadful visitant, the cholera, ready to add its awful presence to the typhus and its kindred. The Commission has a great field and a great opportunity, and their action is well regarded not of mere local import, but of a somewhat national character. If it succeeds in preventing disease, to a great extent, and in lessening the rate of mortality, the example of New York will probably be copied by other cities. We bid them God speed in their formidable undertaking.

Notes and Comments.

The Cholera.

The country was startled on the 10th inst., by the announcement that the emigrant steamer, England, on her passage from Liverpool to New York, had been compelled to put in at Halifax to seek medical aid, having had on the passage 160 cases of cholera, and 50 deaths. She now lies below the lighthouse at Halifax, and every precaution is taken to prevent the spread of the disease. The passengers are mostly Irish and Germans, and the captain thinks the disease was brought on board by the Germans.

Tracts for the People on Hygiene.

The threatened visitation of cholera to our country, has had the effect of inducing the authorities of our larger cities to do more or less to prepare for its reception and mitigation, by adopting proper hygienic measures, and by diffusing information among the people in regard to the proper means for preventing it, and managing it, if it should appear.

We have before us a tract by Dr. Snow, Superintendent of Health, of Providence, R. I., entitled, "Causes of Sickness in Dwellings." It is a four-paged tract, and is No. 2, of a series of "Tracts for the People." The hygiene of the different parts of the dwelling house is plainly and effectually set forth, and must be productive of much good. We trust that information of this kind will be widely diffused by our authorities, in all our large cities, and throughout the country. It will be found to be the best economy to spend a little money in this way, and it should be constantly done, and not merely on such occasions as the present. Dr. Snow is also having a thorough sanitary inspection made of the city of Providence. The same is being done also by the officers of Health of most of our large cities.

In this connection we would take occasion to call attention to the great difference between the true physician, who by diffusing information among the people, and recommending proper sanitary measures is endeavoring to prevent the appearance of cholera, and the miserable ghouls whose sickening and panic-producing advertisements of cholera specifics, in letters an inch long, disfigure the majority of our newspapers. Advertisements of this kind, we are sorry to say,

form no small portion of the reading of too many of our religious newspapers.

Books, &c., Received.—Descriptive Catalogue of Fluid and Solid Extracts in Vacuo; also, Concentrations and Officinal Pills, prepared by Henry Thayer & Co. With Formulas and Receipts (Recipes?). This elegantly got up book is intended, we suppose, chiefly as an advertisement for the manufacturers, but it contains much that will be found very interesting and useful to the physician.

Communicate with Henry Thayer & Co., Cambridge, Mass.

Correspondence.

DOMESTIC.

Lime Inhalations in Diphtheritic Affections.

Editor Medical and Surgical Reporter:

I am glad to meet with the *criticisms* of your correspondent, Dr. T. A. Reamy, upon my letter that appeared in the Reporter of March 10th, because that by discussion truth is oftentimes elicited, and important facts are thus brought to the notice of the profession, which, otherwise, might remain a long time in oblivion; and because it affords to me an opportunity of stating more specifically the nature of the lime treatment, my method of using it, and the reasons why I was led to adopt it. The letter referred to, was written in a hurried manner, and did not contain a full report of the case, and was not intended for publication, as I stated to you at the time, but simply as further confirmation of the lime treatment, as recommended in the communication that accompanied it, and which is published in the Reporter of March 24th, but the correction of a small error made by the "compositor" will, I think, lead the doctor to agree with me that I was not mistaken in my diagnosis of the case.

I wrote,—"the boy had been exposed on last *Thursday*, (that very cold day which will be remembered by us all,) and at night was taken with hoarse cough, and fever," etc. The compositor has it "last *Saturday*," which makes a difference of two days, and I know that the doctor is not prepared to assume that "spasmodic croup," which he seems to be very sure the case was, would last, accompanied with fever and hoarse cough, and the patient confined to bed for three days, which was really the length of time my patient was sick, before I visited him.

And the doctor will certainly not charge me with recommending the lime inhalation, as a *specific* in diphtheria and membranous croup, when he mentions in the same connection the fact, that I used "hive syrup, calomel, rhubarb," etc. I was aware of the objection, that a comparatively new treatment in a disease so formidable as the one under consideration, would meet in the minds of physicians. And in the same letter stated in language similar to that used by your correspondent: "That I had frequently employed new remedies in the treatment of disease which had been recommended by others with great confidence, but that in my hands I had often been disappointed in obtaining like favorable results," and that, I feared that others would regard my recommendations with like distrust, and hesitate before adopting the treatment, which was more particularly given in the communication that accompanied my letter. And it was only after having given the treatment what I regarded "a fair trial," that I felt warranted in presenting the matter through your columns to the consideration of the profession at large.

Although I have read the article which appeared in the Reporter of Sept. 9th, taken from the *Brit. and For. Med. Chir. Review*, in which favorable report was made of several cases successfully treated by lime inhalations; yet the mode of applying the treatment was so vague, that I could not see in what way the lime was brought in contact with the membrane in the air-passages to dissolve it, and did not attempt to use it, although at the time an epidemic of diphtheria was prevailing in this city.

In Wood's *Practice of Medicine* we find it also stated, in speaking of the nature of the false membrane in pseudo membranous croup, that it is dissolved by alkaline solutions, and strong acetic acid, and in the treatment, that alkalies have been administered and were strongly recommended by some writers, supposing that they would have the power to dissolve the secreted membrane, as they are known to do out of the body. That at one time they had obtained quite a reputation, but have since fallen into neglect.

After having obtained the false membrane expectorated by the boy, John Wills, I placed a portion of it in lime water, and found that it dissolved very readily, and then felt satisfied that if some method could be devised to bring the lime in contact with the membrane in the windpipe that it would dissolve it there; my ingenuity was put to the task to discover some means by which this desired object would be accomplished.

I obtained some unslacked lime, and placed it

in a vessel, and poured upon it first cold water, and upon inhaling it could discover no effects.

I then poured over another portion *hot* water, and inhaled the stream arising from it. After inhaling it a few moments, I could distinctly feel in the air passages, the smarting action of the lime, and determined to try the effects of the lime inhaled in this way in the next case of diphtheria, or pseudo membranous croup, occurring in my practice.

In this process, the steam arising from the lime in slacking, contains in it particles of lime which are thus by inhalation brought in contact with the membrane in the windpipe.

I have used it in this way, and so have others with the results already reported to you, and also at the same time have administered lime water internally; I must confess, rather more *empirical*, than *rational*, but with the hope that it would have some influence in preventing or arresting the formation of the membrane.

Dr. A. Shuleck of this city, and one of your subscribers, reports to me this morning two cases of pseudo membranous croup successfully treated by the lime inhalations, and it is to be hoped that in its further trial by the profession, it will prove to be a valuable remedy, but it is not claimed as a *specific* in the treatment of these heretofore unmanageable diseases.

Truly yours, A. Geiger, M. D.

Dayton, Ohio, April 6, 1866.

News and Miscellany.

Pension Examining Surgeons.

The following are recent appointments:

Iowa—Dr. French, Davenport; Dr. Denny, Nashua.

Dr. Woodman, of Michigan, and Dr. Hodges, of Indiana.

—— Dr. Conolly, perhaps the most eminent consulting physician in insanity cases, died recently in England. He was chief consulting physician to the Hanwell Lunatic Asylum and the Asylum for Idiots. He was the author of various works in connection with the subject of his studies, but will be best recollected by the general public by his curious article, published not long since, "On the Madness of Hamlet," a paper evincing great thought and which evoked considerable discussion.

—— Dr. Winship, of Boston, now weighs one hundred and sixty pounds, is thirty-two years of age, and can lift a ton and a quarter.

—— *Charivari* has a picture of the cholera, as a horrible spectre, rousing the slumbering International Commission by a fierce attack.

MARRIED.

Lehlbach—Sautermeister.—On the 12th inst., at Newark, N. J., by Rev. Fred. A. Lehlbach, Dr. Charles F. J. Lehlbach and Miss Emile Bertha Sautermeister.

Brooks—Ramsey.—On Tuesday, March 27th, in Chelsea, Tenn., at the residence of the bride's father, Dr. Frank A. Ramsey, of Memphis, by the Rev. Dr. Hines, rector of St. Mary's church, Almon Brooks, M. D., and Miss Mary A. Ramsey.

Kissam—Eacker.—In Brooklyn, April 4, at the residence of the bride's parents, by Rev. Hugh S. Carpenter, Daniel W. Kissam, M. D., and Carrie M., eldest daughter of John H. Eacker, Esq., all of Brooklyn.

Richardson—Symonds.—In Marlow, N. H., April 4, 1866, Dr. A. P. Richardson, of Walpole, N. H., and Sylvia F. Symonds, of Marlow.

Rowland—Kingsbury.—On the 11th inst., by the Rev. Andrew Longacre, Mr. Harvey Rowland, Jr., and Miss Emily B., eldest daughter of Dr. C. A. Kingsbury, dentist, all of this city.

Sanford—Cutler.—April 11th, by Rev. Dr. Bacon, Dr. Leonard J. Sanford and Miss Anna M. Cutler, all of New Haven, Conn.

DIED.

Brown.—In South Reading, Mass., April 6, Dr. J. G. Brown.

Conant.—In Brooklyn, N. Y., April 11th, John C. Conant, in the 13th year of his age, son of Dr T. J. Conant.

Hubert.—In this city, on the 8th of January last, of scarlet fever, Harry Hubert, aged 23 months. On the 12th of January last, of scarlet fever, Eugene Hubert, aged 3 years and 6 months. Also, on the 8th inst., of typhoid fever, Victorine Hubert, eldest daughter of Dr. Charles and Virginia Hubert, in the 14th year of her age.

Lassing.—In New York, at the house of her son, Dr. H. Lassing, on Thursday, April 12, after a long and painful illness, Mrs. Gertrude H. Lassing, in the 72d year of her age.

Mack.—At Kankakee, Ill., April 3, the Rev. W. B. Mack, father of Dr. A. W. Mack, of the *Chicago Republican*, aged 69 years.

Sickler.—At Carpenter's Landing, N. J., Ivy Sickler, infant daughter of Dr. J. R. and E. L. Sickler, aged 2 years and 8 months.

Stevens.—In this city, on the 8th inst., after a short illness, Henry Hart, son of Dr. A. H. Stevens, aged 22 years.

Wade.—At his residence, Brooklyn, L. I., on Thursday, April 12, T. Anderson Wade, M. D.

Wetherill.—In Lambertville, N. J., on the 11th inst., Dr. Wilfred H. Wetherill, late of the United States Navy, aged 22 years and 16 days.

ANSWERS TO CORRESPONDENTS.

Dr. A. H. H., St. Clairsville, Ohio, and others.—The "Caoutchouc Bag of Herves," the common gum bottle, recommended by Meigs as a pessary, cannot be obtained.

Dr. L. D. W., Messengerville, N. Y.—We can send you Churchill on Diseases of Women, by mail. The price is $4 in cloth, or $5 in leather binding.

Dr. S. C. E., Orillia, Canada West.—Ziegler on Nitrous-oxide, sent by mail, April 10th.

Dr. L. S., Washington, D. C.—Turnbull on Nervous Deafness, sent by mail, April 14.

Dr. W. S., Noblestown, Pa.—Turnbull on Defective and Impaired Vision, and do. on Nervous Deafness, sent by mail, April 14.

Dr. G. I., Aledo, Ill.—The same works sent by mail, April 16.

METEOROLOGY.

April,	2,	3,	4,	5,	6,	7,	8,
Wind	N. E.	S. W.	S. W.	S.	S.	N. E.	N. E.
Weather	Cl'dy, Rain.	Clear.	Clear.	Clear. Heavy Fog.	Cl'dy. Rain.	Cl'dy. Rain.	Cl'dy. Snow & rain.
Depth Rain	1-10				3-10		9-10
Thermometer.							
Minimum	36°	38°	40°	47°	57°	43°	34°
At 8 A. M.	45	47	51	54	65	43	36
At 12 M.	47	56	62	65	77	45	37
At 3 P. M.	44	55	63	70	79	46	36
Mean	43.	49.	54.	59.	69.50	44.25	35.75
Barometer.							
At 12 M.	30.3	30.3	30.3	30.2	30.1	30.2	30.1

Germantown, Pa. B. J. Lehon.